Statement of
Dr. Thomas Horvath, Chief of Staff
Houston 'Michael E. DeBakey' VAMC
Before the
Subcommittee on Health
Committee on Veterans' Affairs

March 11, 2004

Mr. Chairman,

Thank you for inviting me to address the Committee on the topic of Post Traumatic Stress disorder in the context of the overall availability of mental health services in the Veterans Health Administration, with special attention to the needs of our newest groups of veterans from the battlefields of Afghanistan and Iraq.

I am a physician with internal medicine and neurology training from Australia and psychiatric training from this country. Since my arrival to the U.S. 30 years ago, I have served veterans in the VA in every capacity from resident, to staff psychiatrist, to section and service chief, to Chief of Staff, and as the director of mental health in VACO for six years. I am currently the Chief of Staff of one of the largest VA Medical Centers, now named after the legendary cardiac surgeon and WWII veteran, Michael DeBakey. Here, I am responsible for all the clinical activities of a primary and tertiary care, medical, surgical, psychiatric, acute and rehabilitative hospital, which now services over 70,000 veterans in East Texas. I am a professor in the Menninger Department of Psychiatry, named after another famous veteran, in the Baylor School of Medicine in Houston. I have traveled very widely and site-visited most VAMCs. I have gained first-hand familiarity with the mental health scene in the VA by working closely with the Committee for the Seriously Mentally Ill Veteran since it's conception, by Congress in 1994 to advise the USH on all aspects of mental health, including PTSD, and to evaluate VHA's efforts in this regard and then inform to Congress. Our Annual Reports have been constructive, but outspoken, and have pointed to many areas necessary for the improvement in the delivery of critical mental health services.

This has never ceased to amaze me, as I grew up in a Europe caught between Fascism and Communism, where free speech was a rare commodity and a dangerous practice. I grew up in a Europe that sent it's sons to war and slaughter in profligate numbers, and then abandoned them to their fate or even persecuted them for their political beliefs or even for being conscripted for the wrong side. You see, I am the son and grandson of combat veterans. As my father lay dying in 1991, his delirious mind took him back to his field hospital where his soldiers were dying for lack of supplies. My grandfather's four-year service in the trenches left him with a stutter, shellshock, and several wounds. (My other grandfather died as a POW.) Thus for me, PTSD is a family experience and vivid reality, not a textbook abstraction. It is not a personal experience, as my ten-year service in the US Army Reserve taught me the Combat Stress Doctrine, but did not expose me to it. My periods of mortal danger during the 1956 Hungarian Revolution against communism were too brief, too exhilarating; Patton's 3rd Army brought our incarceration by the Nazi's in 1945 to a happy ending. Still, having seen the ravages of war in my country of birth and in my family; having seen the delayed effect of Changi Prison, the Burma railroad and the New Guinea Campaign in my Australian patients, I expected to learn a lot more when I came to the wealthy United States. Imagine my disappointment when in a three year residency training(1973 – 1976), at the Palo Alto VA, I had no instruction what-so-ever in military medicine, post deployment psychiatry, or even participated in an honest discussion of the pain of returning Viet Nam veterans. None of my twelve classmates have served in the military (although the impact of witnessing the shattered lives of veterans was such that, two of us joined the VA and a third went into the Navy). What we learned, we learned from veterans. Later, I learned a lot from Dr. Larry Kolb, WWII Navy veteran, eminent psychiatrist, and one of the people who shamed and scientifically convinced the APA to develop a formal definition for PTSD for it's Diagnostic and Statistical Manual, which the VA eventually followed. So this very real condition, affecting hundreds of thousands of veterans of all wars, finally received a name and a grudging recognition in 1979-1980. To this day however, some ill informed people fail to distinguish between a politically and culturally defined set of attitudes and complaints, the so-called "post-Vietnam syndrome" and a clinically coherent, statistically valid, formal diagnostic entity (DSMIV, APA, 309.81, 308.3).

One of my current patients exemplifies the distinction. He fought with the Marines who lifted the siege of Khe Sanh, endured fear, saw mutilated bodies, escaped close calls. Yet, he says today, " I don't deserve to be in the VA, other people suffered more, done more in combat." He does not draw a pension, has been a self-supporting small businessman. He believes the war had a purpose, and most American fought for a just cause and fought well. He never abused his family, though both his marriages ended due to the severity of his symptoms. These he controlled in Vietnam, not wanting to appear a coward, and suppressed by heavy social drinking afterwards. However, he had three hospitalizations in the last 15 years and has walked around with a loaded gun for weeks. He still has startle reactions; he can't watch Viet Nam theme movies, avoids other veterans. He has nightmares and frequent awakenings. He is withdrawn, has few social contacts, and his business failed due to his increasing isolation (and the loss of money in Enron shares). He has neuropsychologically proven memory and concentration defects. He meets all the necessary criteria for PTSD (309.81), but he does not have the Post Vietnam Syndrome.

Yet, many people to this day regard what I just described as a weakness, a yellow streak and not the red badge of courage. These beliefs die hard, even though well replicated brain scan studies of veterans with PTSD have shown physical shrinking of a part of the brain which controls emotion and memory, called the hippocampus. This atrophy correlates closely with the intensity of combat experienced decades ago. Scientists in the VA and affiliated eminent universities have also shown biochemical changes persisting for these decades that eventually result in higher rates of cardiovascular disease and possibly cancer (This was shown for WWII combat veterans and POWs.) So PTSD is not a little old "adjustment disorder" which is "all in the veteran's head" it is not a hyped-up myth; it is a persistent, dangerous biological condition that maims the body as well as the mind, the brain as well as social relationships. It strikes the brave: the more combat you see, the more intense is your PTSD. (Yet some people are resistant to it to some extent) But it also strikes the lonely; unit cohesion provides a buffer, and a warm homecoming greeting and social support tends to prevent it – but the absence of these provides a multiplier, the beginning of a vicious cycle.

Unit cohesion fell apart in many outfits in Viet Nam as the American part of the war was winding down. And warm homecomings were often missing – and I am sorry to say, the VA often was not a welcoming place either for Viet Nam veterans. I have served ten years in the Bronx VA and when I arrived, the conditions in some areas were as appalling as described by Ron Kovic and portrayed in the Film *Born on the 4th of July*. It should come as little surprise that the fifteen-year-old Research Triangle study has shown persistently high rates of untreated PTSD among Viet Nam combat veterans. However, it took our committee members and others almost eight years of arguments to have VHA commit to a follow-up repetition of that study, this time looking at the physical complications of PTSD, of enormous importance you would think. Dr. Keane is very familiar with the frustrating process of having to make our own VA face-up to it's own needs for data relevant for planning for what should be, but rarely is, the central mission of the VA; to bind the wounds of war. We are grateful however, to the USH who finally cut through the bureaucratic wrangling, and as we speak, a contract is being set. We are also grateful to some of his predecessors who supported the establishment of the National Center for PTSD, the finest research and education institute of its kind in the world, and for developing specialized treatment programs for PTSD. We are grateful that a previous USH finally listened to the repeated urgings of Congress, and established the first MIRECC six years ago. We now have eight of these centers and our USH has authorized the release of an RFP for the next two. He was perceptive enough to appreciate their success; the first three MIRECCs have brought in $ 33 M research income last year in return for a core funding of $ 5.4 M; over the past five years published 1,165 articles of veteran relevant research in the literature, educated thousands of providers, and brought forth new discoveries like the orphan drug Prazosin that so successfully treats combat related nightmares, that not only VA doctors, but Army physicians at Madigan are using it with OIF veterans.

I emphasize these positive developments because VHA has improved its services for some specialized mental health services. Twenty-five years ago, we had no PTSD services, no Vet Centers, no homeless services; now we do! The growth of PTSD services especially have been very gratifying; yet, it has not kept up with the demand.

Personal communication with staff deployed to and returning from the combat and communication zones reveal that servicemen and women are still reluctant to reveal their symptoms or their level of stress. Thus any superficial counts of overt clinical presentations may underestimate the real extent of the disorder. We should painfully remember the laudatory articles in the military psychiatric literature of the late 60's, that bragged that R&R and individual rotations virtually eliminated combat stress disorders in

Viet Nam (for an excellent analysis, see several chapters in War Psychiatry, Volume of Textbook of Military Medicine, OSG, USA, 1995). Combat stress continues to cause casualties, even as the application of CSC principles prevent or delay some; thus the need for VHA/MH services continues. But remember, while the consequences of stress certainly include PTSD as the lead element, combat stress is associated also with suicide, unexplained physical illness, depression and even the precipitation of schizophrenia and bipolar affective disorders. Thus, we must be able to provide not only our outstanding, drop-in, frequently veteran-run, Re-adjustment Counseling (Vet Center) Services that we can be very proud of, but also be able to provide a wide range of acute and rehabilitative mental health services. These must be relevant to the age, sex and ethnic composition of today's military, yet we must continue to honor our commitment to veterans of previous conflicts.

Yet, here the news is not good enough. The SMI Committee has repeatedly observed that VHA needs to increase capacity for specialized services for the mentally ill. This is pronouncedly so for substance abuse services that saw a decreasing number of veterans treated and a decreased amount of real dollars, due to the precipitous closing of a whole range of services six years ago. If we look at the inflation-adjusted dollar; VHA took 25% inflation adjusted dollars and 23% of staff from mental health services and transferred it to primary care or medical/surgical services. These latter have shown significant dollar growth over the past six years, while mental health suffered a relative decline. Now this was not the result of a single executive decision, but was the unintended consequence of hundreds of individual, probably well-meaning decisions to force setting up primary care, improve access to ever-larger numbers of veterans, and to enhance our preventative medicine standards. These were laudable goals, and we proudly achieved them, but at the expense of some of the mentally ill.

It is also entirely clear, however, that with appropriate network level leadership, good local planning and attention, this salutary increase in access to primary care did not have to come at the expense of the mentally ill. Some networks did an entirely fine job in maintaining capacity for the treatment of mental illness. Others did a terrible job. The somewhat unsatisfactory national average hides some truly bad scenarios and fails to reward some excellent performers.

Before my arrival in Houston 5 years ago, the Medical Center already reduced the average length of stay in psychiatry to 7-10 days, had closed beds and units, but had wisely retained the savings to beef up outpatient services. They actually increased the number of patients treated with no detectable loss of quality. They completely closed inpatient substance abuse, but were able to refer needy patients to community beds. Despite their best efforts, the number of substance abuse patients treated as outpatients declined, but some of the missing patients were probably picked up in our Homeless Program. Fortunately, the latter was well funded, both by VACO and the VAMC, and is one of the best in the country. Yet, even our Homeless Program could not prosper without collaboration from the non-profit U.S. Vets and the AmeriCorps programs and the City of Houston (and the cooperation of veterans who often use their own funds to pay for community rehabilitation beds). We have developed a well regarded, well staffed Trauma Recovery Program and has engaged in funded PTSD research and training. Our people have studied the Iraqi War Veteran Clinician Guide; the PTSD Compensation and Pension Exam Guide; we have an OIF Clinical Coordinator and plans for the special treatment of younger soldiers away from older, chronic veterans. As we are not in a big military town, as a lot of the wounded seem to be heading to Tricare and not the VA, and as many transitioning new veterans have yet to discover the VA, we have not had a major influx yet. We are conscious of the concerns of soldiers about being labeled and stigmatized. We have mental health clinicians "embedded" in our primary care clinics and our two satellite country clinics and we work closely with our two urban Vet Centers.

We continue our investment in mental health just as much as in primary care. In fact, we refurbished our 6th floor mental health area the same time as we expanded our 1st floor primary care facilities. We also invest in science; have a MIRECC, a PADRECC, an HSRD Center of Excellence, all working at least in part on mental illness.

To illustrate our dilemma, let me tell you an incident from my Beaumont Clinic, which is experiencing a 20% growth annually. One of my excellent internists told me of two new patients he saw back-to-back. One, was a well-dressed cold war era CONUS served veteran, with diamond rings, who heard about VA's prescription medication benefit while playing poker, and who clearly asked for a set of expensive cholesterol lowering and BP maintaining medications (no, he did not ask for Viagra, but many do). The other was a young woman injured in the service who also experienced military sexual trauma. Fortunately this country clinic of ours does have a psychiatrist, but many CBOCs still have no mental health services despite years of warning by our Committee. (I understand, however, that our USH may have some late-breaking news in this regard.) So we did end up providing services to both veterans but how long can we do so and whom do we prioritize? Let me be clear: I not only applaud the extension of primary care services and preventive medicine, but I personally contributed to their development in Northport twelve years ago, and in Houston over the past five years. But in neither case did I take it out of the hide of services for the mentally ill. We competed for extra funds dedicated for the mentally ill when they were available. These were useful as seed money, but did not comprise our core funding. We simply managed our core allocations fairly and with stewardship and with an understanding that mental illness was real and combat PTSD and its complications were at the heart of what the VA was established for.

I regret to report that there are stigmas in the VA about the mentally ill. In this, we may be no worse than the rest of healthcare, as the President's New Freedom Commission identified stigma as a major obstacle to the freedom of the mentally ill; and the Surgeon General said in 1999, "For our Nation to reduce the burden of mental illness, to improve access to care, and to achieve urgently needed knowledge about the brain, mind, and behavior, stigma must not longer be tolerated". VA needs to do better, because much of the mental illness among veterans is the direct result of their faithful military service and combat experience (look at our service connection rates and the overseas experiences of more than half of our patients, not just those with PTSD, but those with bipolar, addictive, schizophrenic disorders).

I am pleased that VA has established an action agenda to respond to the President's New Freedom Commission report and is developing a strategic plan for mental health programs to be released later this year.